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ABSTRACT

This collection of conference materials presents papers on the following topics: (1) approaches and targeting; (2) the BABES Substance Abuse Prevention Program for Children; (3) a prekindergarten substance abuse prevention education curriculum; (4) a parent-oriented, pilot Head Start primary prevention, drug education project; (5) evaluation considerations; and (6) dissemination efforts. Authors' names and titles of papers include: Lee T. Dogoloff, "Early Childhood Education Drug Abuse Prevention Curriculum Materials Program: Approaches and Targeting"; Sue Bredekamp, "Drug Abuse Prevention and Education for Preschool Children"; Maxine Willis, "BABES Substance Abuse Prevention Program for Children"; Patricia L. Newell, "I'm So Glad You Asked: Pre-K Substance Abuse Prevention Education Curriculum, Education from A-Z"; Michael D. Klitzner, "Evaluation Considerations for the Early Childhood Education/Drug Abuse Prevention Curricula/ Materials Project"; and Carole Levine, "Dissemination Paper." The conference agenda and a list of attendees are provided. (RH)

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**Mini-Conference for the**
**Early Childhood Education/Drug Abuse Prevention**
**Curricula/Materials Project**

The Caucus Room
One Washington Circle Hotel
District of Columbia

AGENDA

THURSDAY, JUNE 8

8:00am Continental Breakfast

8:30am Opening Remarks

Nelson Smith
Acting Director
Programs for the Improvement of Practice

Amy Peck
Mini-Conference Chairperson

8:45am Roundtable Introduction of Participants

9:00am **Discussion of Approaches and Targeting**

Paper presentations by:

Barbara Willer [for Sue Bredekamp]
National Association for the
Education of Young Children

Lee Dogoloff
American Council for Drug Education

10:15am Coffee Break

10:30am **Curriculum Development Presentations** by:

Maxine Willis
BABES Program Director
Babes Substance Abuse Prevention
Program for Children is a puppet show
presented by network of trained adults

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Patricia Newell
Co-creator of "I'm So Glad You Asked"
Pre-K drug abuse prevention curriculum
substance abuse specialist teamed with
Head Start professional to independently
develop this curriculum and materials

Ura Jean Oyemade
Howard University, Department of Human
Development Professor and Developer of
"Getting a Head Start Against Drugs"
a project being piloted in Baltimore

11:15am Question and Answer, and Discussion:
Participants and Curriculum Developers

12:00pm Lunch Break

1:15pm Discussion and Debate of
Approaches, Targeting, Marketing, and Components

3:00pm Break

3:15pm Continue Discussion of
Approaches, Targeting, Marketing, and Components

5:00pm Adjourn

FRIDAY, JUNE 9

8:30am Continental Breakfast

9:15am **Discussion of Evaluation**

Paper presentation by:

Michael Klitzner
Pacific Institute for Education and Evaluation

10:30am Coffee Break

10:45am **Discussion of Approaches to Dissemination**

Paper presentation by:

Carole Levine
Family Resource Coalition

12:00pm Adjourn

**EARLY-CHILDHOOD EDUCATION DRUG ABUSE PREVENTION**
**CURRICULA/MATERIALS PROJECT MINI-CONFERENCE**
**June 8-9, 1989**

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Early Childhood Education

Drug Abuse Prevention Curriculum Materials Program

Approaches and Targeting

Lee I. Dogoloff

Executive Director

American Council for Drug Education

Selecting an appropriate approach is critical in carrying out the congressional mandate to develop and disseminate age appropriate materials for drug abuse prevention efforts with pre-kindergarten age children. A number of options present themselves, including health awareness, safety awareness, self esteem development, decision-making skills, stress release, and/or drug prevention education.

An initial review of some of the characteristics of pre-kindergarten children might be helpful in setting the stage.

- The immediate and the apparent absorb the child's attention
- Thinking is still literal and concrete
- Children at this age are very egocentric

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- Pre-kindergarten children have poorly developed reasoning power

- Young children are single minded, and their thinking involves lots of fantasy

- Young children have a limited attention span

- Short term memory is just beginning to be developed

- Pre-kindergarten children are impulsive

- Education capabilities are such that long term memory is limited and they have little understanding of "rules"

- Young children are sociable, showing increased interest in other people

- Pre-schoolers spend the majority of their time in social play activities

- Language, play, and dreams enable the children to begin to use symbols

The conclusion reached by the National Association for the Education of Young Children in their position statement on

developmentally appropriate practice and early childhood programs serving children from birth through 8 years old, suggests that children in the pre-kindergarten age group learn most effectively through a concrete play-oriented approach to education. Children learn through all of their senses and need to be taught accordingly. The key here is to concentrate on the physical, emotional, and cognitive development of young children.

Parents as Models:

Many studies have shown that parents have a powerful effect on their children's growth and development. Starting in infancy, children begin to imitate other people -- especially their parents. Children imitate their parents' attitudes and feelings, their words and their actions. As primary educators, parents model behavior through their own attitudes towards lots of things including risk taking, injury, life and other people. They teach children language associated with their environment and inculcate habits which make an indelible impression on their children. In all aspects of learning, parental behavior provides a strong influence on the child's subsequent development.

Children imitate parents for a number of psychological-social reasons. The child maintains parental affection by behaving in a fashion similar to that of the parent. The child develops a sense of identity by learning to distinguish between people who act like "us" and people who act like "them." The child may

identify with an adult out of fear of punishment. The child may identify with an adult because of the promise of rewards or by observing that adults who act in a particular way are rewarded. In fact, children are likely to identify with any adult since they see all adults as powerful.

Young children will imitate adult behaviors even in the face of contradictory verbal messages. In other words, in mixed messages sent out by adults, children often detect behavior to be a stronger clue. This is well established in the literature. Parents' mixed messages may add to children's difficulties coping with life. Studies have shown that parents unconsciously contribute to their own children's accidents by modeling unsafe ways to deal with dangerous situations such as traffic.

Discussion:

Given the limitations of children's abilities to learn, and their reliance on learning through play, specific drug abuse information needs to be geared to the children's developmental level. For example, information on specific drug effects is unrealistic for this age group, but they can learn the difference between drugs and medications. The conclusion reached by the National Association for the Education of Young Children, is that children in this age group learn most effectively through a concrete play-oriented approach to education. Therefore, whatever might be created as a drug abuse education activity

should break down the information into discrete, concrete units the child can absorb. However, in terms of planning effective programs, it is equally important to concentrate on parents and other caregivers, given the key role they play in the child's development at this time.

The importance of the parental role was established for me, in reviewing an early elementary school program in North Carolina entitled "I'm Special" which taught refusal skills to 4th and 5th graders and attempted to enhance their self-esteem. These children were followed through the 12th grade and compared to a control group not exposed to "I'm Special" to study the impact of drug and alcohol use patterns. There were significant differences in favor of far less drug and alcohol use among those exposed to "I'm Special" through the 8th grade. But after the 9th grade, all the differences disappeared. One conclusion to be drawn from these results is that the reason the gains were not sustained was due to the failure to involve parents in the program so that they could become consistent reinforcers of values and knowledge associated with drug and alcohol refusal through the turbulent adolescent years. Virtually all exemplary early childhood programs rely heavily on a parental or adult caregiver component.

A 1987 Lou Harris poll found that more than 3/4 of parents of very young children named drug abuse as their greatest fear for

their children. This establishes that parents are anxious about this issue and are a potentially receptive target for the program. Given the realities of early childhood developmental processes and abilities, combined with the apparent anxiety of parents regarding this issue as well as the key role they and other primary caregivers, including daycare providers, play in the lives of these youngsters, it would seem most appropriate to target efforts at these adults. After all, parents are the primary educators of their children and drug and alcohol prevention is not only a matter of transmitting knowledge to children, but more significantly of values and attitudes against the use of illegal drugs. Furthermore, involving the parents at this early point can pay continuing dividends since they will hopefully have a basis for helping their children avoid drug and alcohol use as a child grows and matures.

What should the focus of parental/caregiver programs be?

- First, the central importance of their role should be established. They are the most important influences in the lives of their children. What they **DO** as well as what they **SAY** will make a difference.

- Issues around modeling behavior should be emphasized. Young children are like sponges in absorbing and imitating the behavior of important adults in their

lives. This is especially true as it involves drug and alcohol use. Parents should obviously abstain from all use of illegal drugs and use alcohol in a legal and responsible manner. This includes such issues as not drinking before driving and paying particular attention to the very influential modeling role of older siblings.

- Modeling around the responsible use of prescription and over the counter drugs is also important. Adults should be established as the "gate keepers" for medication, thereby communicating the notion that adults, not children, make decisions about when and how much medication is taken. It also establishes the notion that taking medicine is not a casual issue.

- Self-esteem has often been touted as important in drug abuse prevention. To the extent that this is true, it is not something that can be taught -- rather it is developed as a result of the experience children have in relating to the adult world around them. The importance of developing self-esteem is potentially related to good decision making about risky behaviors, including drug and alcohol use. Specific techniques for interacting with children in ways that enhance self-esteem should be emphasized. The same may be said for decision making and development. Issues such as respect for the child,

allowances for individual differences and incremental age/appropriate opportunities to make decisions should be considered part of the adult training program.

In summary, the most likely approach to achieve success in providing primary prevention programing for pre-kindergarten youngsters should be directed at parents and primary caregivers, as well as children themselves, and should emphasize the following:

- Adults and particularly parents are the most important influence in the lives of these children and that influence is established by what they do and what they say;

- The importance of adult modeling behavior must be established;

- Behaviors on the part of adult caregivers which enhance self-esteem and develop good decision making skills should be stressed; and

- Children's programming should convey age-appropriate information through a concrete play-oriented approach which emphasizes health and safety awareness as well as decision making skills.

# Drug Abuse Prevention and Education for Preschool Children

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Approaches and Targeting

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Introduction

With the proliferation of drug abuse and related problems reaching epidemic proportions in American society, it is not surprising that the educational system is seen as an important vehicle for addressing prevention strategies. Likewise, with research supporting the importance and value of early childhood education, there has been a downward extension to the preschool level of curriculum issues that have traditionally been reserved for older children. This trend is due in part to the success stories of early childhood programs. Research on long-term effects of high quality preschool programs has demonstrated that children who receive such an experience are less likely to be retained in grade or assigned to special education, are less likely to become delinquent or pregnant, and are more likely to complete high school and obtain productive employment. Extrapolating from these findings (which cannot be generalized to all early childhood programs), we find that preschool programs are now being called on to "cure" many of society's ills. Curriculum for preschoolers is now available on global problems as intransigent as world peace, environmental pollution, AIDS, child abuse, and other forms of violence. The major premise of this paper is that solving society's problems is not the responsibility of young children; it is the responsibility of adults to protect children from potentially harmful experiences

and to help children develop emotionally, socially, and cognitively, so that they can cope with the complexities of their experiences. Drug prevention curriculum for preschool programs must emanate from this basic premise of adult responsibility. Given this caution, there are appropriate approaches and vehicles for incorporating drug prevention in the preschool curriculum.

The Omnibus Drug Initiative Act of 1988 directed the Department of Education to develop "age-appropriate drug abuse education and prevention curriculum for preschoolers". The key word in this directive is "age-appropriate." The early childhood profession, represented by NAEYC, has taken strong positions defining developmentally appropriate practice for young children (Bredekamp, 1987), which guide the development of educational resources for preschoolers. NAEYC's definition of developmentally appropriate practice encompasses age-appropriate information. In short, what is generally to be expected of children of different ages and stages should provide a framework for planning curriculum. Therefore, the first question curriculum developers must ask is, what are preschool children like and how do they learn? NAEYC's definition of developmental appropriateness has a second dimension, however, and that is, individual appropriateness. Each individual has a unique pattern and timing of growth and development as well as individual interests, cultural background, and learning style. For a program to be developmentally appropriate, it must not only be age-appropriate (i.e., designed to apply generally to

four-year-olds), but it must also be individually appropriate (i.e., relevant and meaningful to the particular group of children served by the program). The task of individualizing curriculum is usually left to the classroom teacher or at least to the curriculum specialists in a school district. But questions about individual differences should not be neglected by curriculum developers, particularly when the target population is young children. In fact, a principle of appropriate early childhood education is that the younger the children, the more curriculum must be relevant and meaningful to the daily lives and firsthand experiences of the learners.

Some of the general principles of appropriate practice to consider in developing curriculum are:

1. All areas of children's development and learning are integrated.
2. Children learn best through firsthand, concrete experiences with objects and interactions with other people. They do not learn complex concepts by coloring workbooks or marking correct answers on a ditto sheet or sitting down and listening to adult lectures.
3. Children learn through modeling. They are better at observing and modeling the behavior of significant adults than they are at listening. The models provided by powerful, esteemed adults, such as parents and teachers, are most influential.
4. Children construct their own knowledge from their own experience. They try to relate new experiences to something

they already know (assimilation) and they actively struggle to make sense out of the world. They are far more reasonable than most adults realize.

Drug abuse is a complex issue which defies simplistic solutions. Nevertheless, some approaches derived from basic principles of how children learn are more developmentally appropriate than others. Following are some parameters within which drug abuse prevention curriculum for preschoolers should be addressed.

## Preventing Drug Abuse for All Children

The most appropriate curriculum approach to prevent drug abuse with the broadest target population is to design curriculum that promotes the development of self-esteem and social competence. Research demonstrates that children who are neglected or rejected by their peers are more likely to suffer adjustment problems and delinquency, and to drop out of school. Research also shows that these children can be identified at the early childhood level and that through minimal adult intervention, their social competence can be significantly improved. A major emphasis of all early childhood programs should be these two critical dimensions of social-emotional development. Recent emphasis on academic skills has caused preschool programs to unduly neglect the areas of development where they can have the most valuable, long-term impact.

Along with social competence and self-esteem, a critical skill for preschoolers is decision-making. Early childhood classrooms should be structured so that children have a variety of meaningful choices and so they experience the consequences of their choices. Expecting adolescents to "Just say no" to drugs when they have never had the opportunity to learn how to make decisions is unreasonable. Health and safety are also important topics for all preschool children, and knowledge about avoiding dangerous substances of all forms should naturally be incorporated in all curriculum on health and safety.

Drug Prevention for At-Risk Populations

The term "at-risk" is becoming overused and meaningless. For the purposes of this paper, it is used to refer to children who are members of subpopulation groups that American society has put at risk. Since being born poor and a member of a minority group is a risky proposition in America, it is primarily low income and minority children who are "at risk", although other groups also qualify for this dubious distinction including children with various handicapping conditions.

For at-risk populations, the primary drug abuse prevention strategy is not substantially different than for all children -- promotion of self-esteem. Accomplishing this goal is somewhat different, however, with different populations. For example,

promotion of self-esteem in at-risk populations must incorporate strategies that help children overcome the biases that are so prevalent in our culture. For at-risk groups, multicultural curriculum is not sufficient; active intervention to counteract bias is essential (Derman-Sparks, 1989).

For curriculum to be age-appropriate, it must also be individually appropriate, that is, derived from children's firsthand experiences. Unfortunately, for many at-risk children, exposure to drug abuse in their community is part of their daily experience. These experiences will naturally be reflected in children's language, their social interactions, their dramatic play, and the ways in which they express emotions. As a result, age-appropriate curriculum provides opportunities to express strong feelings in socially acceptable ways, such as telling or dictating stories, painting pictures, building blocks, or role playing. The teacher's role in all this is to help children develop strategies to appropriately express fears and concerns and to help them develop skills such as nonviolent conflict resolution and decision-making. Such teaching requires particular skill and is the result of training.

## Teacher Training

Any curriculum for preschoolers, but particularly one that is as sensitive as drug abuse education, must incorporate teacher training

materials. In order to implement the goals mentioned above, teachers need assistance with at least three areas. First, they need to understand child development and particularly moral development during early childhood. For example, most young children think what is bad is what is punished. Second, they need specific training in how to promote the development of social skills. They need to know how to help isolated children establish relationships and how to set and enforce clear limits and simple rules of behavior. All preschool classrooms could operate effectively with three basic rules: We don't do things that 1) hurt other people; 2) hurt our environment; or 3) hurt ourselves. However, children don't learn these rules by coloring a worksheet or sitting on a time-out chair. They learn them by living them.

The third area of teacher training is in implementing integrated curriculum. Drug abuse prevention, like other important social learnings, can not be done effectively in a one week unit or during a puppet show. It must be integrated into the overall fabric of issues that children write and read and talk about. It must be dealt with when it arises, not when it is in the lesson plan book.

## Parent Education

Probably the most important and potentially effective approach to drug abuse prevention is parent education. It is unrealistic to think that preschool programs, many of which are only half-day in

duration, can counteract the more salient and lasting impact of the family and community. Drug abuse, including alcohol and tobacco, is common at all socio-economic levels and in all communities. However, children who live in poverty are at greater risk. Clennie Murphy, of the National Head Start Bureau, recently reported in a public meeting that in some Head Start programs, as many as 30% of the parents are involved with illegal drugs. So the problem for some children is not only immediate, it is urgent.

The approach to parent education cannot be moralistic. A more appropriate, and potentially more effective approach is to educate parents about basic child development. All parents need to understand how children learn through modeling and that their children are more likely to do what they do than what they say. Parents also need training in some of the basic areas mentioned above for teachers, such as how to help children become independent, critical thinkers, develop self-control and self-discipline, and most importantly, acquire a sense of self-esteem and social competence.

## Conclusion

All of the approaches described here are perhaps more meaningfully illustrated through an example. On the morning of March 31, 1981, I found myself observing in a kindergarten classroom in the District of Columbia. The morning began as usual with Show

and Tell, mostly Tell in this instance. The morning was unusual, however, because the preceding afternoon an assassination attempt had been made on the life of President Reagan. That morning there was still a great deal of uncertainty as to the prognosis of the President and the three other men wounded in the shooting. Not surprisingly, the assassination attempt was the prime topic for "telling" that morning. With a cool detachment that Dan Rather would envy, one child after another stood and calmly and accurately related the events of the shooting. "The bullet entered the left loft of his lung". "Mr. Brady was shot over his left eye and the bullet passed through the right side of his brain." At least ten children "shared" various aspects of the shooting incident. The teacher's only response to the chilling reports was to repeatedly say, "The President is feeling better now." Following the allotted 20 minutes of "Show and Tell", the teacher proceeded to the phonics lesson for the day which concerned words beginning with the letters, "qu".

How could that morning have been different? What if the curriculum had been more age-appropriate as well as individually appropriate? Time spent squirming during Show and Tell could have been spent in child-initiated activities, among which could have been dramatic play where children could express strong feelings. Children would also have had an opportunity to dictate stories or use a computer to write them. Children's feelings would definitely have been expressed in art work. Parents would then have been able

to see the stories and pictures and follow-up with their children discussing their own values about guns and violence. All of these opportunities for important social, emotional, cognitive, and moral development were missed.

Fortunately, presidential assassination attempts are rare events in children's lives, but drug abuse and its effects are far too common. Drug abuse education and prevention are serious and vital issues that should be addressed through a comprehensive approach that includes parent education, teacher training, and age-appropriate curriculum for children. No quick fix or band-aid will suffice.

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Fact Sheet for Presentation by
Maxine Willis

# BABES
## Substance Abuse Prevention Program for Children

### 1. Reason for the Creation of the BABES Program

In 1977, Lottie Jones, President and Chief Executive Officer of the National Council on Alcoholism and Other Dependencies - Greater Detroit Area, perceived the need for a program such as BABES and conceived what needed to be done to accomplish this monumental task. As a recovering alcoholic with ten (10) years of sobriety at the time, there were no substance abuse services available that were relevant to children. After listening to others recovering from chemical addictions and people in therapy, it was apparent that a program such as BABES was needed before the onset of the problem and that help should begin during the formative years, but no later than three (3) years of age. It was all very simple. The way to prevent substance abuse and many other problems was to start education very young. Since her training was in administration, she needed the assistance of an educator. Maxine Willis, a pre-school teacher, applied for a position indicating the desire to do something about substance abuse. This desire culminated as a result of observing a group of two and three year olds playing "tea party", during which they were pretending to drink whiskey and smoke pot. With Ms. Jones' administrative background and Ms. Willis' elementary education background, BABES was born which subsequently grew into BABESWORLD.

### 2. Approach

BABESWORLD is a total systems approach to the prevention of substance abuse. It utilizes a comprehensive training program targeting and integrating multiple systems (youth, family, schools, media, community organization) with the multiple strategies (providing accurate information, life skill development, facilitator trainings, and stimuli to change community policies and norms) required to create an environment which allows youth to lead healthy, drug free lives.

The program is delivered through the use of seven areas of training focusing on: self-image and feelings, decision making and peer pressure, coping skills, getting help, alcohol and other drug information, living in chemically dependent homes, and community organization.

The information is conveyed through metaphor. Stories are used which are tailored to address each of these populations. These stories are factual renditions of occurrences that actually happened to people, i.e., children, parents, teacher, community leaders, etc., and these occurrences are replicated in the stories.

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The dream and goal of BABESWORLD is to be to Prevention what Alcoholics Anonymous is to Recovery: A program which (1) works; (2) is easy to learn and implement; (3) is universally applicable (4) is affordable; and (5) generates within participants zeal sufficient to keep the program alive and continue program growth to reach more children.

3. Populations Served

The populations targeted by the curriculum/program are schools, families, children, social agencies, churches, government, business and the media.

4. Components Involved

All modules of BABES utilize a multi-media delivery approach. Included are curricula, workshops, games, puppets, a life size puppet musical production, and thirty-one (31) songs with music and lyrics written especially for BABES. Other teaching accessories include tee shirts, buttons, pins, stickers and coloring books. As an integral and required part of the program, training is provided to teachers, parents and others who will be presenting to youth, families, or organizing the community.

BABES in the Schools (age 3 to 18)

The P-12 curriculum is broad based and designed to teach general life/coping skills with a wide range of applications, as well as situations and problem specific approaches; this is the basic element of BABES.

There are three levels: Basic (3-8), Intermediate (9-13), and Advanced (14-18). Each has a series of seven lessons in story form, illustrating basic living skills, enlivened by seven puppet characters with clearly defined personalities representing various prevention concepts. By utilizing story-telling, enhanced with puppets, the "child" within every study is reached immediately. BABES curriculum includes 29 stories covering real life problems gathered from over 1,000 pre-school through high school age youth.

Pre-School BABES (ages 1 1/2 to 3)

BABES and the Family provides substance abuse prevention techniques for use by parents with emphasis on developing positive parenting skills.

BABES for Clinicians was created especially for use by therapists in clinical settings. BABESTART is for use with the entire family, and BABES KIDS is for use with very young children from chemically dependent homes in a group setting.

BABES in the community is designed to show community groups how to use BABES to organize entire communities to combat alcohol and other drug abuse. This component is comprised of BABES Alive! BABES in the Government, BABES in Business, BABES in the Church, BABES in Social Agencies, and BABES and the Media.

5. Timetable and Costs

1979 - The first class held in Buttons and Bows Nursery in March.

1980 - Program officially named BABES; the curriculum and the first set of hand made puppets were developed and presented at the National Council on Alcoholism Forum in Seattle in April, 1980. First school system to utilize BABES - Bloomfield Hills (MI) in April 1980. Six consecutive lessons in six weeks was provided to all early elementary classes.

1982 - First BABES Kit developed a few weeks prior to April, 1982 when it was presented to the National Council on Alcoholism Forum in Washington, D.C.

Because the creators were on staff at the National Council on Alcoholism and used considerable voluntary services, the actual productions costs are difficult to compute, however, a marketing firm has indicated that the Basic BABES multi-media kit would cost approximately $25,000 to $30,000. The actual amount spent was approximately $5,000 which included the artists costs and the production of the first puppets.

6. Evaluation Methods and Findings

Since the early 1980's, pre/post tests have been given to children in pre-school and elementary school settings. It was found that BABES has a significant learning effect upon the children involved, and even resulted in behavioral changes among some of the children involved in the BABES program.

Since its inception, five evaluations have been conducted on the BABES program and they are now part of a Doctoral Dissertation by Ms. Jones which will become the foundation of a twenty (20) year longitudinal study.

Please see attached listing of evaluations conducted for details.

7. Lessons Learned

- Puppets are a valuable tool in conveying concepts to children. They allow children to give feedback.
- Parents wanted something for themselves.
- Something was needed to reach each person where they were, i.e., each segment of the community.
- Flexibility is a must.
- Music is a way to convey and translate concepts.
- Real life situations were critically important.
- System needed to be in-place to meet problems which surface.
- People need to be bonded together, thus development of the family concept.
- People can't be put out of a family, thus development of the healthy family.
- Adolescents can be used to present BABES.
- Parents appreciated being a part of a process which addressed their own need as well as giving them a language to use when talking to their children.
- Adolescent and RSVP senior citizens receive therapy by being BABES helpers.
- Children are not isolated from the community in which they live and have to be viewed and taught in the context of the whole community.
- Training of presenters, parents, etc., is crucial to the implementation process.
- It became necessary to implement the BABES Academy which is a fully licensed day care facility and serves as an evaluation laboratory.
- It is important to take risks, live on the cutting edge and become independent/fiscally autonomous.
- Other programs were developed as a result of the Basic BABES curriculum.
- The program needs to present material with respect to the way children experience it in life.

When faced with the absence of an existing knowledge pool from which to draw for guidance, we learned the importance of the story of the Little Red Hen: "I'll do it myself, she said, and she did!"

PROGRAM EVALUATION
SUMMARIES

Drs. Don Marcotte, Adger Butler, Institute for Research and Evaluation, Wayne State University, Detroit, MI, 1983

BABES: Pre/post testing in four elementary schools: N-97. Clearly observed behavioral changes in the students as a result of BABES. Younger children might benefit from a more intense exposure to BABES. BABES should be adapted for even older children. Efforts should be made for greater parental involvement. BABES is achieving its goals of educating children effectively.

Drs. Sally Harvey, Melvin Raider, City of Detroit Project, Wayne State University, Detroit, MI, 1984

BABES: Pre/post testing of eight to nine year olds; N-26. The percentage of children achieving mastery of the concepts increased from 4% to 92%. BABES is achieving its goal of educating the children effectively.

April Goff Brown, Dir. of Prevention, Regional Alcohol and Drug Abuse Resources, Inc., (RADAR) Hartford, Conn., 1984

BABES: Pre/post testing at six day care centers; N-174. BABES provides the opportunity for children to learn to think and teachers the lessons of natural and logical consequences and judgement. BABES is realistic literature and an excellent program in both the topics and methods used. However, BABES does need parental involvement in order to reach its full potential.

Brigg Dates, M.A., Joel M. Ostro, Ph.D., Parkview Consulting Services, Birmingham, Mi., 1985

BABES: Pre/post testing of three through nine year olds; N-102. BABES has a significant learning effect upon the children involved. The ability of children to answer some questions correctly on the pretest serves both as a method of affirming previous learning and as a way for them to feel less overwhelmed by the program, having already achieved a modicum of success.

Big BABES: Pre/post testing of parents; N-23.
Attitude testing demonstrated parents are amenable to changing their attitudes regarding materials and information presented. Knowledge testing revealed a significant increase in learning over the course of the program in both parent/child relationships and substance abuse. Parenting skills testing revealed a sensitizing to their actual parenting skills. Big BABES meets its goal of introducing parents to resources available in their geographic area. The program seems to pave the way for attitude and behavior change as a consequence of increased knowledge.

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Fact Sheet for Presentation by
Patricia L. Newell

"I'm So Glad You Asked."
Pre-K Substance Abuse Prevention Education Curriculum.
Education from A-Z.

1. Reason for Creation of the Curriculum/Program

Need was expressed by co-author, Marguerite Sheehan, who at the time was a Head Start Teacher, experiencing situations in her classroom which she felt needed addressing (ie. children acting out family situations involving substance abuse during free-play activities). Current curricula, primarily designed for grades 1-12, were reviewed at that time (1985), and none were found to be developmentally appropriate.

The following factors were considered: a. Children of Alcoholics/Addicted family systems are the highest risk group for adopting/repeating addictive behaviors later in life, b. Early Childhood is a critical period for Identity Formation, and the development of Basic Trust and Self Esteem, and c. Resources were scarce.

Therefore; the need for the development of a Curriculum/Program was clear.

2. Approach

The Curriculum is designed to prevent/reduce children's negative experiences with drugs/drug abusers through promoting self esteem, the development of coping skills, and responsible and informed decision making skills. Basic factual information is also included. The Curriculum is designed to be integrated into weekly classroom activities vs. a one - six week "drug unit."

3. Populations Served

Teachers targeted through Curriculum introduction, individual lesson plans, Curriculum resource section, and a Curriculum Training including factual information on drugs of choice in the 1980/90s as well as information on family substance abuse and addictive systems ie. community, workplace, etc. (optional/highly recommended).

Children targeted through lessons and activities including: films, puppets, slide show, music, movement, coloring book, and a variety of visuals.

Parents targeted through take home activities designed for children and parents, and encouraged teacher/parent involvement with classroom projects.

4. Components

Components include a variety of sensory learning opportunities such as - twenty lessons, photo boards, puppets, music, movement, slide show, and a variety of visuals.

5. Timetable and Cost

| | |
|---|---|
| Writing and materials development/search | (1.5 years) 1985/86. |
| Field tests, one academic year | (9 months) 1986/87. |
| TOTAL COST: (no labor) | $10,000.00. |

6. Evaluation Methods and Findings

Following a twenty hour Teacher Training, a nine month field test was conducted. Programs included:

| | |
|---|---|
| Methodist Community Daycare (rural) | 2 classrooms |
| Multicultural/Bilingual Head Start (inner-city) | 2 classrooms |
| Multicultural Head Start (suburban) | 2 classrooms |
| Public School Kindergarten (rural) | 6 classrooms |
| TOTAL: (+ 500 children) | 12 classrooms |

Findings: N=50

- All teachers considered training a critical component.
- For the most part, the Curriculum was much needed and very well received.
- We were very pleased to see that teachers remained enthusiastic throughout the process, and expressed a marked increase in comfort around discussing issues related to substance abuse in their classrooms.
- Teachers stressed that the use of the Curriculum aided in 'breaking the silence' around not only the issue of substance abuse, but other difficult issues including: physical abuse and violence, incest, feelings, divorce, death and dying, etc.
- Teachers also expressed an appreciation for an awakening of and/or new sense of understanding/comfort around dealing with their own issues related to alcohol and other drugs.
- Only occassional roadblocks were met, most of which were discovered to be linked to a teacher/provider's personal history (past and/or current experiences involving alcohol or other drug abuse in their own lives or the lives of people close to them).

Note: Difficulty handling sensitive information and different levels of denial should be anticipated and addressed as part of any program(s) and/or trainings designed to address difficult and `loaded' issues such as substance abuse.

- There were instances throughout the field tests where teachers, presenters, and/or parents took issue with the curriculum content of a particular lesson (ie. discussing the safety of cirgarette smoking made several adults uncomfortable in that they did not wish to have their behavior questioned by preschoolers). Most conflicts regarding content were able to be discussed and resolved. Some issues, however, were not resolved. In those instances compromises were reached and additional information/referral sources were offered as 'food for future thought.'

7. Lessons learned

- Be prepared for extensive self-evaluation and be open to personal issues related to substance abuse in your own lives - denial included!
- Know that it will be expensive to produce a quality product - materials, etc.
- Be prepared to meet with some resistance along the way.

Remember throughout the process, that there will be a good number more people who appreciate/benefit from your efforts than there will be those who resist them.

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# PARENTS AND CHILDREN GETTING A HEAD START AGAINST DRUGS

## 1. Reasons for the Creation of the Curriculum/Program

The need for an early childhood Head Start curriculum in substance abuse prevention was dictated by the increasing incidence of substance abuse in low income families and communities. Moreover, a group of minority scholars involved in Head Start research determined that in the Head Start target population, there was an increase in the incidence of substance abuse among Head Start parents which puts Head Start children at greater risk for substance abuse. And, since treatment programs have been less successful, research suggested that primary prevention targeting high risk groups is a key to reducing the overall demand for drugs. Thus, when the solicitation for national prevention programs was issued by the Office of Substance Abuse Prevention (OSAP/ADAMHA), the Minority Scholars, headed by Dr. Ura Jean Oyemade, (presenter) teamed with the National Head Start Association to develop a proposal which was subsequently funded.

Specific objectives are to:

- Inform parents regarding the risk factors that tend to be associated with later substance abuse in children.
- Develop effective family management skills to create an environment that reduces risk for substance abuse by strengthening skills in interpersonal resistance, social problem-solving, and emotional coping.
- Establish a values/alternative condition in which knowledge and skills are aligned with an understanding of how attitudes encourage drugs and abuse.
- Educate young children about the problems of drug use and teach them to say no to drugs.
- Develop skills to reduce young children's susceptibility to drugs. Use a cognitive interpersonal skills approach to reduce aggressive and other antisocial behaviors in very young children while increasing children's academic self-confidence through preschool education in the home.

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- o Align knowledge and skills with the understanding that attitudes and practice of unsafe behaviors encourage children's unsafe behaviors.

2. Approach Used

The curriculum was designed for both parents and children. It was guided by research which identified factors that place certain families at higher risk of substance abuse (e.g. poor communication, low self-esteem, inadequate family management, excessive drinking) and characterisitics which would make drug abuse less likely to occur in families (e.g. warm positive relationships, strong kinship networks, commitment to education, and reasoned democratic discipline style).

Specific curriculum content focused on drug information, self-esteem, communication, stress, drugs in the community, health issues, values and peer pressure, family management and relations, and developing support networks.

The model employed to develop the curriculum relied on four themes: definitional, social, intrapersonal, and interpersonal, as well as the need for support networks.

3. Population Served

The target populations are low-income minority children (Black and Hispanic) who are enrolled in Head Start, and their parents. Activities were designed to incorporate cultural aspects of these groups so that they could relate and incorporate practices in their daily lives.

4. Components

The parent curriculum is an experientially based skill development approach. There are ten sessions with a variety of lecture, discussion, role playing, self-assessment, puppet construction, and other activities.

The children's curriculum is integrated into the regular classroom curriculum and includes games, coloring with crayons, songs, etc. In addition, at home activities are incorporated to have parent follow up classroom activities with child.

Trainer's guides were developed for both the parents' and the children's curriculum. Training video tapes were developed for training parent trainers and teachers.

5. Timetable and Cost

The development of the pilot curriculum was completed over a six month period, November 1, 1988 - April 1, 1989. Piloting and revision will entail an additional six months and will end October 31, 1989.

The total cost of this project, including piloting, was $150,000. Costs involved curriculum development, training staff, evaluation staff, curriculum materials, typing and production of curriculum. Funds were provided by OSAP/ADAMHA.

Implementation materials should average around $25.00 per participant. This includes activity books, materials and refreshments.

6. Evaluation Methods

A pre- postexperimental and control group design was employed. Thirty experimental and thirty control parent-child pairs at each of eight sites were included in the evaluation design. Instruments were designed to assess knowledge, values, attitudes, self-esteem, stress, and several other factors.

Results are not yet available.

7. Lessons Learned

- Teachers, parents, and children are very responsive to the need for drug abuse prevention at the early childhood level.
- The parent curriculum should not be too lengthy to reduce the likelihood of parents losing interest.
- Primary prevention beginning at the preschool period, which involves the family, is critical to the reduction of the demand for drugs.

# EVALUATION CONSIDERATIONS FOR THE EARLY CHILDHOOD EDUCATION/ DRUG ABUSE PREVENTION CURRICULA/MATERIALS PROJECT

Michael D. Klitzner, Ph.D.
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In the best of all possible worlds, the impact of drug abuse prevention materials would be thoroughly evaluated before they are widely disseminated. Perhaps the most compelling argument for evaluation is to be found in the Hippocratic Oath -- "First, do no harm." A surprisingly large number of drug abuse prevention strategies, including some that are widely used in our nation's schools, appear to encourage drug and alcohol use as often as they deter it, at least under some conditions. An even larger number of drug abuse prevention strategies appear to do nothing at all. These "do nothing" strategies are not harmless. They waste time and money, and their continued use may eventually erode public trust (or at least test the public's patience) concerning our ability to address the nation's drug and alcohol problems.

Thus, we cannot be sanguine that an apparently innocuous venture like drug abuse prevention is without the potential for doing harm as well as good. This is especially the case in largely uncharted territory such as drug education for preschoolers.

Unfortunately, we do not live in the best of all possible worlds. Careful evaluations of the impact of drug and alcohol abuse prevention programs take time and money. In the current

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case, a well conducted outcome evaluation would take a considerable amount of both, since the target population cannot be expected to exhibit the target behavior at all for almost a decade, and not in large or meaningful numbers for even longer. It is unlikely that we will want to wait that long to decide whether or not the materials should be disseminated.

Given the practical infeasibility of an impact study of the Early Childhood Drug Prevention Curricula/Materials, at least one that measures drug and alcohol abuse as its primary outcome, what role should evaluation play in the materials development process? There are several options that should be considered, depending upon the type of materials to be developed. Before discussing these options, I think it is prudent to consider just how much attention should be given to evaluation overall. The answer to this question lies in the nature of the materials themselves and in how much impact (for good or for harm) the materials can be expected to have.

At one extreme would be materials such as video-tapes for children and pamphlets for parents. We can be relatively certain (based on previous experience and research) that such products will have a minimal impact, either positive or negative. Here, it would probably be inappropriate to devote much effort and resources to evaluation beyond a simple "consumer review."

At the other extreme might be "therapeutic" approaches--i.e., those aimed at building personality traits (e.g., self-esteem), affecting attitudes or beliefs, or changing parent or

care-giver behavior. These approaches are designed to effect fundamental changes in psychological or social functioning. As such, they have much more potential impact (good or bad) on participants, and deserve much closer scrutiny. This is especially the case given the age of the target population. Here, as much emphasis on evaluation as is practical and financially feasible would seem warranted.

## EVALUATION OPTIONS

I will discuss four evaluation options, roughly in the order in which they would actually be implemented in a materials design project. The first three options should be considered for any materials. The decision whether to implement the fourth option (formal field evaluation) will depend upon the nature of the materials and the considerations just discussed.

### OPTION 1 - CONCEPTUAL EVALUATION

Unfortunately, many ideas in drug and alcohol prevention have been developed into programs and strategies without first stopping to examine their conceptual soundness. Although many current programs claim to be theory based, the relationship between program activities and theory is often tangential and sometimes illusory. When these relationships are examined, it often becomes obvious why the programs have failed -- there was

no reason to expect them to be successful in the first place.

Clearly, there are gaps in our knowledge of the relationship between early childhood development and later substance abuse, and we are plowing relatively untilled programmatic soil. However, we are by no means without a scientific basis upon which to plan the initiative. Therefore, the first evaluation option to be considered should be a <u>conceptual evaluation</u> of the strategy(ies) proposed. Although a conceptual evaluation is not what one usually thinks of as "evaluation," this step can save wasted effort on an intrinsically bad idea.

At a very minimum, the contractor or ED staff should be required to provide satisfactory answers to the following questions:

1) For whom, specifically, are the materials or activities to be designed? For whom may they be inappropriate?

2) What risk factors for drug and alcohol abuse are to be addressed by the project? That is, what characteristics of the target population or their environment that contribute to increased or decreased risk of later drug and alcohol-related problems are to be remediated and/or strengthened? What evidence is there in the research literature that these factors are important for the specific target population?

3) How, specifically, are the activities or materials of the project expected to alter the risk factors? To what extent can the risk factors be expected to be altered (a little, a great deal)? What evidence is there in the research literature that these activities or materials will have the expected effect?

Unless satisfactory answers to these questions can be developed, it is unlikely that the proposed activities or materials will have much impact. Therefore, initiatives for which these questions cannot be answered should probably not be

considered for further development. It would be worthwhile to have the "conceptual evaluation" reviewed by a panel of research experts, although it is ultimately up to ED staff to determine whether or not an idea is worth pursuing further.

OPTION 2 - CONSUMER EVALUATION

A second major reason that prevention initiatives fail is that people do not want to (or cannot feasibly) become involved with them. Parent training will not be effective if parents do not attend. Training video-tapes for pediatricians will not be effective if they are not watched. Accordingly, the second recommended evaluation option is consumer input. Assuming that an idea has "passed" the conceptual evaluation, consumer input should probably be sought before further developmental work is initiated.

Clearly, gaining consumer input from pre-schoolers (if appropriate) will present difficulties. In early development phases, consumer input could be sought from individuals familiar with the likes and dislikes, attention span, and so on of the target population -- e.g., staff of the Children's Television workshop. In later phases (when draft materials or activities have been developed), actual testing with children is essential.

For programs designed to involve adult care-givers or parents, consumer input can take numerous forms, and several types of questions are probably relevant:

1) Would consumers avail themselves of the materials or activities if they were available? Why or why not?

2) What barriers to use of the materials or participation in the activities are envisioned?

3) Do the materials meet a need, or do they duplicate resources available elsewhere?

4) In what format(s) would the materials or activities be most useful?

5) Do consumers feel that they would benefit from exposure to the materials and activities?

Obtaining consumer input should be a regular and on-going activity conducted by the materials development contractor(s). Some projects have found it useful to develop a consumer panel that is convened at regular intervals during the development process. Depending upon the types of materials or activities developed, such a panel may serve an important, on-going evaluative function for the current effort.

## OPTION 3 - IMPLEMENTATION PILOT TEST

A third major reason that prevention initiatives fail is because they are not properly or adequately implemented. Good ideas on paper often disappear without a trace, or become disasters (or near disasters) in the field. For this reason, it is imperative that the materials be pilot-tested for implementation feasibility. If a curriculum has been developed, presenters should be trained and the curriculum delivered to a pilot audience. If parent training has been developed, a pilot group of parents should be trained.

Here, the concern is not the impact of the materials, but whether or not they can be used as planned. Data collection should focus on careful debriefing of both staff and participants, and on careful observation of the initiative as it unfolds in order to assess its integrity relative to its original plan. As is the case with consumer input, any number of questions might be addressed by an implementation pilot test and the nature of the pilot-test will depend upon the specific materials developed. However, some questions regularly addressed by such studies include:

1) What sort of staff are required to implement the program effectively?

2) What other sorts of resources (e.g., special space, special equipment) are required?

3) Is the training provided to staff adequate to allow them to effectively use program materials?

4) Can the program materials or activities be presented in the time allotted? Is there too little material?

5) Do the materials hold participant's interest? Are they too complex? Too simple?

6) Are there categories of participants for whom the program is best suited? Most poorly suited?

7) What are the actual costs of the program when it is implemented in the field?

The implementation pilot-test should probably be conducted by the contractor who develops the materials. This individual is in the best position to identify those questions that will need to be answered in assessing implementation feasibility. On the other hand, such pilot tests are not easy to carry off well. If the contractor does not have demonstrated capability in this type

of assessment, an outside contractor or sub-contract should be considered.

OPTION 4 - FORMAL FIELD EVALUATION

As already discussed, it does not seem feasible to attempt to demonstrate the effects of the developed materials on drug and alcohol use. The time frames are simply too protracted to make such a study feasible. On the other hand, for some of the types of materials contemplated, there are a variety of mediating variables that could be measured in a shorter time-frame. For example, if pediatricians are to be taught methods for providing anticipatory guidance to parents, is such guidance provided in actual office contacts? If general health skills are to be taught to children, do these result in improvements in current health behavior (nutritional choices, safety practices, hygiene habits)? If parents or care-givers are to be taught positive discipline practices, are these implemented in the home?

An evaluation of the impact of the materials on these mediating variables would be highly desirable. The proceeding three evaluation options will help ensure that the materials are conceptually sound, suited to consumer needs, and feasible in practice. However, only a field evaluation, conducted by a third party, will allow us to answer the question (albeit only partially) of whether or not the materials "work."

It is important to note in this regard that a field evalu-

ation is a major undertaking. It is likely that the results of such an evaluation would not be available for at least two years after the materials are completed. Costs for such a field evaluation, depending on the scope, could easily be several hundred thousand dollars per year.

However, the risks involved in not conducting such an evaluation are several. First, as already noted, enough prevention efforts have backfired to indicate the need for field-testing prior to the promotion and dissemination of new efforts. Second, it is possible that the materials will be evaluated anyway (by prevention researchers in search of grant proposal ideas). It would be unfortunate for such an evaluation to show that the materials are ineffective after they have been disseminated. Finally, as consumers of prevention become more sophisticated, it is becoming increasingly common to hear demands for supporting data before materials will be adopted.

Given the expense involved in field evaluations, one possibility would be to devote the Department's resources (or some portion of them) to evaluations of existing materials rather than to the development of new materials. Existing materials could be screened and selected on the basis of a conceptual evaluation as described in Option 1. The most promising materials (i.e., those that stand the test of a conceptual evaluation) could be subjected to feasibility pilot-tests and formal field testing.

DISSEMINATION PAPER

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INTRODUCTION

Intention and effectiveness are not the same. One may intend to accomplish a specific task, proceed with a plan, act on a variety of options and, for all practical purposes, one may accomplish the initial task. The question which remains, however, is how effective was this process in meeting the intended goals. In the Omnibus Drug Initiative Act of 1988, the Congress directed the Department of Education to develop "age-appropriate drug abuse education and prevention curricula, programs, and training materials for use in early childhood development programs." The intent of this legislation goes beyond the development of these prevention materials and programs. The intent also includes the wide dissemination of what is developed to pre-school programs, including Head Start, Chapter 1 preschools, and other non-federally funded programs. The effectiveness of this important initiative -- who it will reach, in what settings, under what circumstances -- is quite dependent on the dissemination efforts related to these products. This paper will offer some perspectives on this dissemination process. It will outline a variety of means of finding the targets for these pre-school focused programs. It will offer options in terms of ways to handle the dissemination process as well as those groups, programs, organizations and agencies who should be targeted to receive these materials.

An initial question to be answered is that of just who the "target audience" is for these materials. The legislation is directed at pre-school aged children (roughly ages 3 to 5 years). The existing federal programs for this age population are reaching small numbers of the children who fall into this category. It is estimated that in 1990 there will be 23 million children in the United States between the ages of 0 to 5 (Cherlin, 1988). Of that projected population, small numbers are presently served in federal programs. Head Start serves 16% of eligible children -- 453,000 nationwide. (Children's Defense Fund, 1988) Chapter 1 (Compensatory Education Act) serves approximately half of those who are eligible, most of whom are elementary school students, although the Even Start program will increase the preschool numbers somewhat. (Children's Defense Fund, 1988) The Social Services Block Grant (Title XX) which funds subsidized day care services for low-income families has experienced cuts in funding over the last 9 years has reduced the numbers of children served. (Children's Defense Fund, 1988) If the goal of the Omnibus Drug Initiative of 1988 is to reach the broadest possible pre-school audience with materials aimed at prevention of drug abuse, then the dissemination effort must look at the widest possible range of programs, organizations and agencies as potential dissemination points. It is conceivable that the materials developed will be distributed beyond the most widely known programs for pre-schoolers (daycare centers, Headstart programs, school-based early intervention programs, nursery school programs, etc.) to some of the organizations and agencies who work with the families of those pre-schoolers who are not presently served by programs. In this way, these preventive efforts will have even greater impact as they draw both parent and child into the process.

The following sections of this paper will focus on three areas:

1. The impact of various kinds of product options (materials produced) on the dissemination process and strategies
2. Key agencies and organizations which might be appropriate targets of dissemination efforts
3. Who should handle this dissemination process.

IMPACT OF PRODUCT OPTIONS ON THE DISSEMINATION STRATEGY AND PROCESS:

At this time, the kinds of materials and products for pre-school age drug abuse prevention efforts have not yet been determined. This information is key in determining the most appropriate dissemination efforts. The types of materials (curriculum, training programs, videos, etc.) have a direct bearing on determining the final distribution targets of these materials. As Chart I demonstrates, the major target audience of pre-school aged children (3 to 5 years old) cannot be "accessed" in a singular way, nor can it be accessed directly. In order to reach pre-schoolers, one must work through some intermediary such as parents and family, school/educational programs, child care centers, early intervention programs, physicians and pediatricians, family resource programs and others. The dilemma of disseminating these products is that they cannot, in most cases, go directly to the target audience.

Curriculum Materials

Curricula are most naturally distributed to those who will implement them -- teachers and caregivers who work with young children and their families. Outreach to these groups can be achieved in a number of ways. They include utilization of an independent contractor to develop and implement a plan for national distribution of these curricula materials to early childhood programs. In so doing, the contractor could be mandated to target specific populations and areas for his/her efforts. It seems logical that a contractor would work closely with the staff of the Department of Education where there is immediate access to federally funded programs (Head Start, Chapter 1, etc.) and to focus the major efforts of such contractors on reaching programs outside of that venue. What is critical in selecting such contractors is their knowledge of and contacts and credibility with agencies, programs and organizations outside of those receiving federal support for their early childhood programs.

An additional means of disseminating curricula materials would be through the use of regional conferences. These might be specific to the materials to be highlighted, or be special additional (possibly invitational) sessions added to conferences already scheduled and in place (National Association for the Education of Young Children - NAEYC, regional and city-wide AEYC conferences, Head Start, National Black Child Development Insititute, Cooperative Extension Network, Family Resource Coalition, etc.). A list of some organizations hosting appropriate local, regional and national conferences is included in Appendix A. Again, it would seem sensible to contract for the development and implementation of such a dissemination process.

Training Programs

Training materials and programs are valuable only if they are utilized. To assure such use, they must reach those whom they wish to "train" and once trained, provide follow-up and support. Such training in the area of pre-school drug abuse prevention can be offered through a variety of organizations and means. Training for providers and practitioners who work with young children and their families is more easily disseminated than is training for parents. The Department of Education can access the State Education Agencies and provide training for providers and educators through their agency networks and regional training sites. Dissemination, in this case, may only involve the distribution of materials and could be handled by the Department of Education.

A growing number of states have instituted (or are in the process of developing) statewide and partial Child Care Resource and Referral systems (CCR&R). A list of those CCR&R's is included as Appendix B. One of the most common features of CCR&R systems is that of providing training and technical assistance to caregivers. CCR&R's are another potential vehicle for dissemination.

The National Diffussion Network is yet another means of distribution to the provider/practitioner population. In addition, the National Clearinghouse for Alcohol and Drug Information (NCADI) is a service of the Office for Substance Abuse Prevention of the Alcohol, Drug Abuse, and Mental Health Administration. Organized under NCADI is the Regional Alcohol and Drug Awareness Resource (RADAR) Network. Each RADAR network member (one per state) can offer information services to the state. Distribution of the training information and materials through the RADAR Network would also reach a broad-based population. Additionally, the same contractor process suggested under Curriculum might also be applied to training materials. The need for familiarity with a broad spectrum of organizations and providers serving the pre-school populations is, again, essential.

It is a bit more difficult to disseminate training to parents. As a group, unless they or their child is already involved in a pre-school program, it will be difficult to target who these parents are. A point to be considered here is the value in reaching those parents whose children are not involved in some sort of pre-school program. Many of these children will not be involved in group experiences until they enter the public school system. Training their parents in pre-school drug prevention techniques could have impact on both parent and child. Reaching these families with the materials and information, however, will take unique dissemination efforts. Access can be made through other agencies and programs working with these parent populations (Departments of Health, Family Resource Programs, Mental Health Agencies, Military Family Programs, Departments of Welfare, etc.). Outside contracting for this kind of dissemination effort seems necessary and should broaden the potential sites for such parent training.

Multi-Media, Video and General Materials

Included in this category are video productions and other forms of media presentation of prevention materials including written materials which might be distributed to the general public (pamphlets, comic books, coloring books, etc.). The purpose in these kinds of efforts is to reach a "mass" audience with prevention information. Disseminating such information through the public media, via television, radio, newspapers and magazines seems to be both a logical and appropriate means of reaching the largest possible audience of parents, practitioners and pre-schoolers. Public television stations could be used for distribution of video presentations. The success of the National Committee for Prevention of Child Abuse (NCPCA) campaign which distributed Spiderman comic books with sexual abuse prevention information and stories serves as a fine example of cooperation between agencies and the media. The comics with their preventive message were included in Sunday newspapers across the country, reaching an broad spectrum of the population. These efforts could be replicated in order to distribute materials and information on drug abuse prevention for pre-schoolers and their parents. In addition, the cooperation of radio and television stations should be sought to provide Public Service Announcements regarding the availability of materials for parents and practitioners. Nationally distributed magazines might also be involved in such efforts.

## KEY AGENCIES AND ORGANIZATIONS TO INVOLVE IN THE DISSEMINATION PROCESS

The task of dissemination of the kinds of materials mentioned in this paper is not small. It is a task which will require the cooperation of many agencies, organizations and groups in order to best reach as many of the pre-school children in this nation as is possible. Utilizing the many existing systems and networks to reach that target audience seems to be the most efficient way in which to disseminate materials. A major piece in this process will be determinining which of the many options is the most appropriate and will make best use of the materials which are developed. Understanding the various options, therefore, becomes critical.

The US Department of Education is the most obvious starting place. Outreach and dissemination to Head Start, Chapter 1, Even Start, and through other federal agencies to Title XX programs. But, as noted in the introduction to this paper, these programs serve only a small portion of the pre-school-aged population in this nation. Many children are enrolled in early childhood programs (pre-school and day care programs) who do not fit the criteria for federally funded programs. Many more children in this age group are not in any kind of pre-school program. Reaching these populations is more difficult. They must be accessed in other ways and reached with this vital information. Appendix C includes lists of various kinds of organizations, agencies and state-wide initiatives for children and families which might be accessed in this process. While this is an extensive list, it should be seen as a starting place. The variety of options in reaching these children and their families continues to expand.

## WHO SHOULD DISSEMINATE

The task of disseminating the materials developed by the Omnibus Drug Initiative Act of 1988 is a large one. What will be disseminated is not yet known. It is conceivable that an extensive variety of materials and training programs could come from this initiative. This makes the dissemination process a complex one, needing the skills and expertise of many who can access a variety of means to get these materials and information to those who will use it and to those who need to have it.

Federal and state agencies (Departments of Education, Health and Human Services, and others) have the capabilities to disseminate these materials within the context of the programs they supervise and support. Most of these agencies conduct regular training sessions and regional meetings for those involved with pre-school aged children and they could utilize those opportunities to train and familiarize programs with these new materials and options. Where such networks exist, it would seem wise to use them.

It may be necessary, however, for the Department of Education to contract with others to organize and supervise this process. The massive amount of work entailed in simply providing this information to state agencies responsible for licensing child care would require outside assistance. The list in Appendix C demonstrates the variety and spectrum of possibilities. Many of those listed might be interested in contracting for the dissemination process itself. They would bring a broad knowledge base, expertise in specific areas, and connections which would enhance the process. More than one contractor may be necessary. Contractors might be chosen through a separate RFP process. It might be useful to contract different portions of the dissemination process to different contractors, based on the kinds of materials to be disseminated or on the populations to be reached.

The dissemination process lends itself to a variety of options in terms of who should disseminate. None of these options should be overlooked. All of them have merit. The optimal situation will take advantage of as many as possible.

## CONCLUSIONS

In her keynote address to the 1988 Family Resource Coalition National Conference, Bernice Weissbourd, President of the Coalition stated "If we care about our own children, we need to care about all children because all will be citizens of this country." (1988) As we look at a process of reaching young children with vital information which can impact their lives, we need to be sure that this process can reach all children. We need to tap existing resources and to look beyond them to other new methods and techniques of reaching others. We need to be effective, not just in our intent, but also in our outcomes. How we disseminate the materials which result from the Omnibus Drug Initiative Act of 1988 will determine to a great extent the effectiveness of the good intent of that Act.

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CHART I

REACHING THE TARGET AUDIENCE (PRE-SCHOOL CHILDREN)
WITH DRUG ABUSE PREVENTION MATERIALS

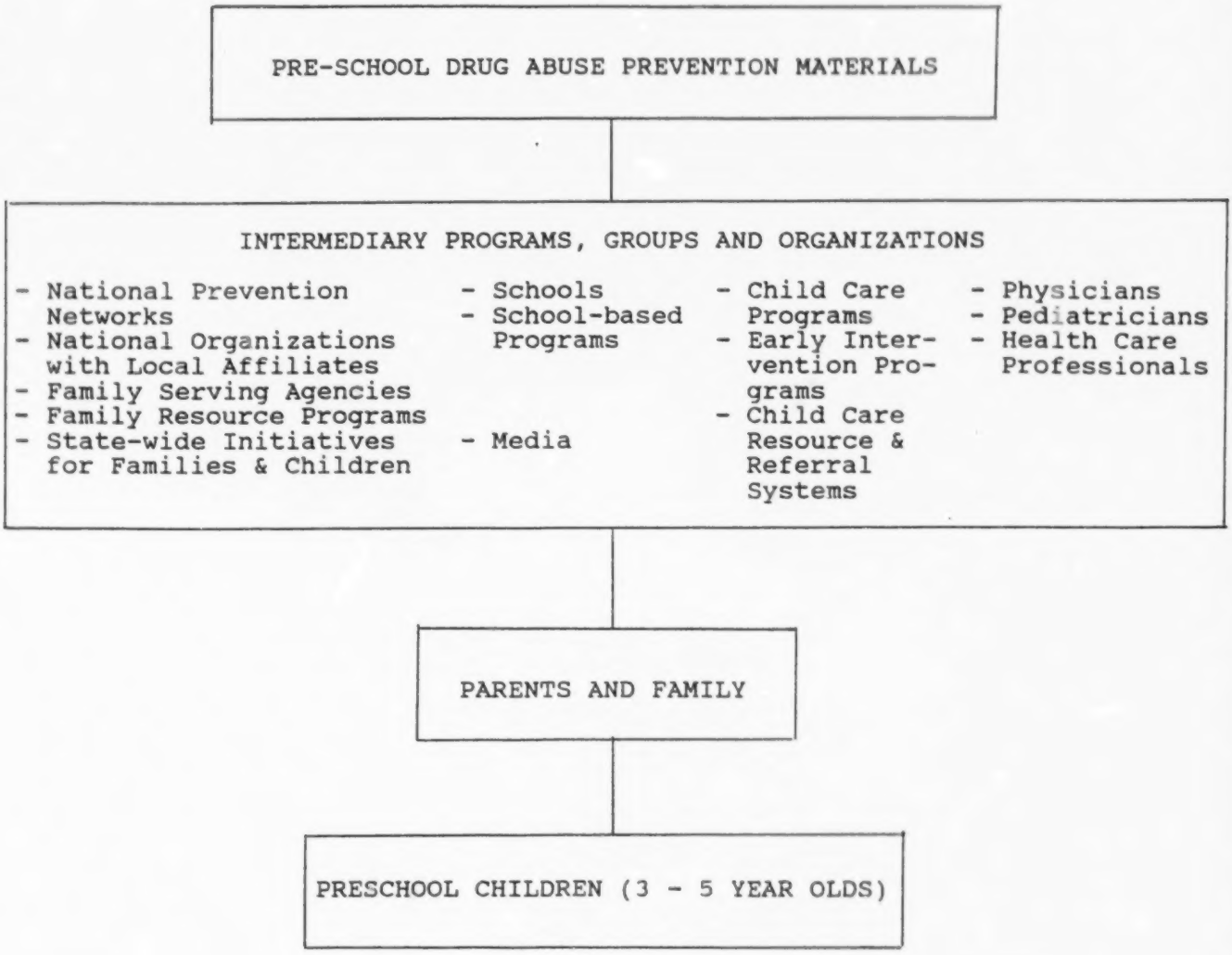
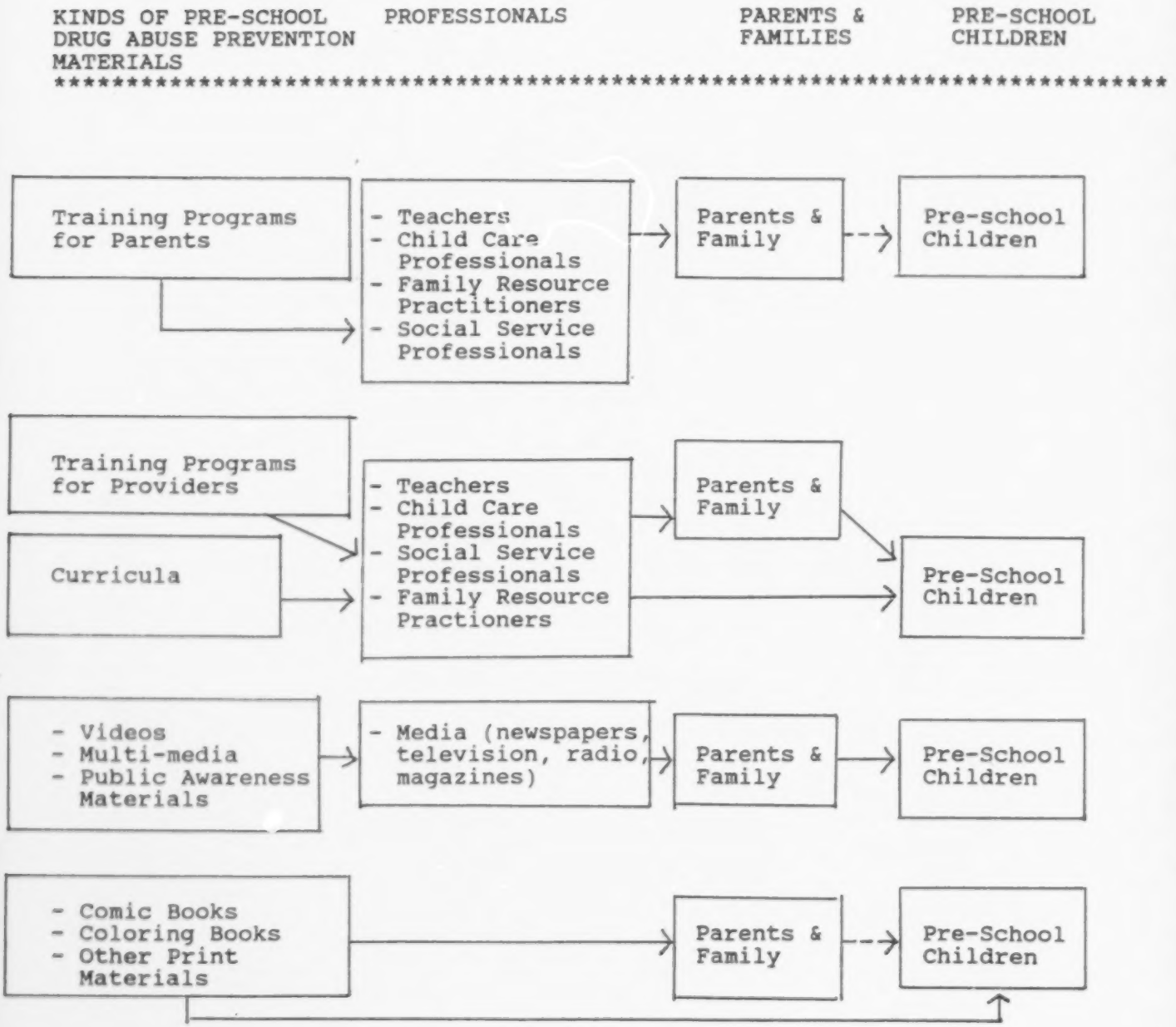

PRE-SCHOOL DRUG ABUSE PREVENTION MATERIALS
INTERMEDIARY PROGRAMS, GROUPS AND ORGANIZATIONS
- National Prevention Networks
- National Organizations with Local Affiliates
- Family Serving Agencies
- Family Resource Programs
- State-wide Initiatives for Families & Children
- Schools
- School-based Programs
- Media
- Child Care Programs
- Early Intervention Programs
- Child Care Resource & Referral Systems
- Physicians
- Pediatricians
- Health Care Professionals
PARENTS AND FAMILY
PRESCHOOL CHILDREN (3 - 5 YEAR OLDS)

CHART II

DISTRIBUTION CHART FOR SPECIFIC PREVENTION MATERIALS



## APPENDIX A

## ORGANIZATIONS HOLDING CONFERENCES APPROPRIATE FOR DISSEMINATION OF TRAINING MATERIALS**

American Orthopsychiatric Association, New York, NY. (annual conference held in the spring)

Child Welfare League of America, Washington, DC. (annual conference and various regional and training conferences)

Children's Defense Fund, Washington, DC. (annual conference and various regional and training conferences)

Cooperative Extension Service, Washington, DC. (national and regional meetings)

Family Resource Coalition, Chicago, IL. (national conference held in even numbered years, training conferences held as needed)

Head Start, Washington, DC. (Conferences and meetings held throughout the year on local, regional and national level)

National Association for the Education of Young Children, Washington, DC. (annual conference in November, regional and local conference held year-round by affiliate groups)

National Black Child Development Institute, Washington, DC. (annual conference)

National Center for Clinical Infant Programs, Washington, DC. (annual conference held in the fall, training conferences offered)

National Committee for the Prevention of Child Abuse, Chicago, IL. (annual conference and regional and local training conferences and meetings)

PARENT ACTION, Chicago, IL. (local parent leader training conferences and national meeting in conjunction with the Family Resource Coalition).

** This is a partial list. There are many other organizations hosting conferences and training sessions which would be approriate vehicles for dissemination of the Omnibus Drug Initiative materials and training.

APPPENDIX B

STATEWIDE AND PARTIAL CHILD CARE RESOURCE AND REFERRAL SYSTEMS

States Funding Statewide CCR&R Systems

1. California
2. Massachusetts
3. New Jersey
4. Rhode Island

States Funding Partial CCR&R Systems or CCR&R Demonstration Projects**

1. Alaska
2. Connecticut
3. Delaware
4. District of Columbia
5. Hawaii
6. Illinois
7. Iowa
8. Maine
9. Maryland
10. Michigan
11. Minnesota
12. New Mexico
13. New York
14. Oregon
15. Pennsylvania
16. Utah
17. Vermont
18. Virginia

** with state dollars; many states also make grants to CCR&Rs of federal Dependent Care Planning Act dollars.

## APPENDIX C

### KEY AGENCIES, ORGANIZATIONS AND PROGRAMS FOR INVOLVEMENT IN THE DISSEMINATION PROCESS*

Federal Agencies and Federally Funded National Initiatives:

- US Department of Education (Washington, DC)
- US Department of Health and Human Services (Washington, DC)
- National Diffusion Network (Washington, DC)
- Military Family Programs (ie. Armed Services Y's)

State Agencies:

- State Departments (Boards) of Education
- Statewide Child Care Resource and Referral Networks (see Appendix B)
- Statewide child care licensing agencies (Departments of Children and Family Service, Department of Human Services, etc.)
- State Departments of Public Welfare

State Initiatives for Children and Families:**

- First Impressions (CO)
- Parent Education and Support Centers (CT)
- Prevention and Family Support Services (CT)
- Mid-Iowa Community Association (IA)
- Ounce of Prevention Fund (IL)
- Healthy Start (KS)
- PACE - Parent and Child Education (KY)
- Maryland's Family Support Centers (MD)
- Friends of the Family (MD)
- Way to Grow (MN)
- Early Childhood Family Education Programs (MN)
- Parents as Teachers (MO)
- Child Guidance Programs (OK)
- Together for Children (OR)
- Parent-Child Centers (VT)
- Today's Children-Tomorrow's Future: Early Childhood Education and Assistance Program (WA)

* These are preliminary lists. A contractor, responsible for dissemination would need to enhance and expand these lists to make them even more comprehensive.

** Additional state-wide intitiatives are beginning in many states (Texas, Mississippi, etc.). These programs are "housed" in various departments (Health and Human Service, Welfare, Children and Family Services, Mental Health, etc.). Each is unique in its compontents, but with an overall goal of prevention, early intervention and strengthening families.

APPENDIX C

National Organizations and Agencies:

- American Academy of Pediatrics (Elk Grove Village, IL)
- Children's Defense Fund (Washington, DC)
- Child Care Owners Association -- representing for-profit child care centers, including many national chains (Kindercare, etc.)
- Cooperative Extension Network (Washington, DC) -- Home Economists Network, connected to Land-Grant Universities, working with all aspects of family life
- Family Resource Coalition (Chicago, IL) -- Family Resource and Support Programs
- MELD (Minneapolis, MN) -- formerly Minnesota Early Learning Design
- National Association for the Education of Young Children (Washington, DC) -- Early Childhood Programs
- National Association of Social Workers (Washington, DC)
- National Black Child Development Instititue (Washington, DC)
- National Center for Clinical Infant Programs (Washington, DC)
- National Committe for the Prevention of Child Abuse (Chicago, IL) - NCPCA also works directly with the Children's Trust and Prevention Funds which should be involved in these efforts
- PARENT ACTION (Chicago, IL)

Religion Affiliated National Organizations:

- Jewish Community Centers (through Jewish Welfare Board, New York, NY)
- National Council of Churches (New York, NY)
- National YMCA's (New York, NY)
- National YWCA's (New York, NY)
- Others, specific to a particular denomination

National Voluntary Organizations:

- American Association of University Women
- Association of Junior Leagues (New York, NY)
- National Council of Jewish Women (New York, NY) -- through the Center for the Child and the HIPPY program
- Others, as appropriate

Other Programs and Organizations:

- Community College Programs (preschool & parent education)
- Parks and Recreation Programs
- Others, as appropriate